Yale HEALTH

Complete this form legibly and upload to:
https://healthontrack.yale.edu

Student Medical Requirements Form

THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY.

All dates must in MM-DD-YYYY format

Any prepopulated vaccination dates on the form are validated and obtained directly from state vaccine registries

LEGAL Last Name	LEGAL First Name	Date of Birth (mm-dd-yyyy)	NETID
Chosen Name	Phone		

Department/Program of Study at Yale (Check one)

○ Undergraduate * ○ Graduate * ○ Summer * ○ School of Medicine ± ○ School of Nursing ± ○ Physician Associate Program ±

Part 1: Required for all Students

IMMUNITY HISTORY		
1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students. Select ONE option		
Option 1	**Measles, Mumps, Rubella (MMR) 2 Dose Vaccination** • First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose. • If above not satisfied, obtain a booster and enter date given, or complete Option 2.	Dose #1: .... ____________ MM - DD - YYYY Dose #2: .... ____________ MM - DD - YYYY Booster (if indicated): ..... ____________ MM - DD - YYYY
Option 2	**Measles, Mumps, Rubella Lab Immunity** • A titer showing immunity to each individual disease is an acceptable alternative to vaccination.	**Required: Upload results to Health On Track** *If not immune, you are required to receive a booster and repeat the titer.
2. VARICELLA IMMUNITY – * ± Required for all students. Select ONE option		
Option 1	**Varicella 2 Dose Vaccination** • First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose. • If above not satisfied, obtain a booster and enter date given, or complete Option 2	Dose #1: .... ____________ MM - DD - YYYY Dose #2: .... ____________ MM - DD - YYYY Booster (if indicated): ..... ____________ MM - DD - YYYY
Option 2	**Varicella Lab Immunity** • A titer showing immunity is an acceptable alternative to vaccination.	**Required: Upload results to Health On Track** *If not immune, you are required to receive a booster and repeat the titer.
Option 3	**Documentation of previous disease** (Must be filled in by MD/APRN/PA-C.)	Varicella disease date: ____________ MM - DD - YYYY
3. TETANUS-DIPTHERIA-PERTUSSIS (Tdap) – * ± Required for all students		
Only Tdap is accepted within the past 10 years	Date of most recent Tdap dose:	____________ MM - DD - YYYY
4. MENINGOCOCCAL Vaccination – * ± Required of all undergraduate and graduate students living in university dormitories		
Meningitis Vaccine (MCV 4) Must cover strains A, C, Y, W-135 (Menactra, MenQUADfi Menveo, Nimenrix, or Penbraya)	Vaccination MUST have been given WITHIN 5 years of your program start date at Yale. **Exceptions to requirement: Students NOT living in university owned dormitories.**	Date: ____________ MM - DD - YYYY

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Part 2: Required for all Health Professions Students

5. TUBERCULOSIS (TB) – ± Required for Health Professions Students – AND students who screen positive on the TB Risk Questionnaire on Health On Track

STEP 1: TB Blood Test/IGRA	*STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB BLOOD TEST		
☐ QuantiFERON ☐ T-Spot Date: ______ MM - DD - YYYY RESULT: ☐ NEG ☐ POS* **Required: Upload results to Health on Track**	**CHEST XRAY** Required if past or current positive TB blood test. Not required if completed medication treatment for TB. Chest X-ray Date: ______ MM - DD - YYYY ☐ Normal ☐ Abnormal	**TB TREATMENT** ☐ Latent TB Infection ☐ Active TB Infection Date(s): ______ MM - DD - YYYY List Medication(s):	**NO TB TREATMENT** If TB treatment was not provided - indicate why below:

6. COVID-19 VACCINATION – ± Strongly Recommended for Health Professions Students – Strongly encouraged for all other students.

- **Please submit documentation of currently available COVID vaccine.**

COVID-19 – currently available seasonal dose	Date: ______ MM - DD - YYYY	☐ Moderna ☐ Pfizer ☐ Novavax

7. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students. Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.

Hepatitis B Vaccine (check one) Completed series: ☐ 2 - dose ☐ 3 - dose	Dose #1: .... ______ MM - DD - YYYY Dose #2: .... ______ MM - DD - YYYY Dose #3: .... ______ (if applicable) MM - DD - YYYY	Hep B Surface Antibody Titer (QUANTITATIVE) **Required: Upload results to Health On Track**

8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted to Health On Track during flu season. Recommended but not required for all other students.

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Part 3: Recommended vaccines based on personal history – (please record if applicable)

OTHER VACCINES - NOT required		
Hepatitis A Vaccine	☐ 2 Dose Hep A	Dose #1: ....________ MM - DD - YYYY Dose #2: ....________ MM - DD - YYYY
HPV Vaccine	☐ HPV 4 ☐ HPV 9	Dose #1: ....________ MM - DD - YYYY Dose #2: ....________ MM - DD - YYYY Dose #3: ....________ MM - DD - YYYY
Meningococcal Serogroup B Vaccine	☐ Bexsero, 2 doses ☐ Trumenba, 3 doses	Dose #1: ....________ MM - DD - YYYY Dose #2: ....________ MM - DD - YYYY Dose #3: ....________ (if Trumemba) MM - DD - YYYY
Yellow Fever	☐ Yellow Fever ☐ Stamaril	Date of dose: ....________ MM - DD - YYYY
Typhoid	☐ Typhoid Vaccine	Date of dose: ....________ MM - DD - YYYY

Part 4: Medical Provider Certification of the Above Information

Medical Provider Name	**Medical Provider Signature**	**Date** ________ MM - DD - YYYY
Address (Include city and state)		**Telephone**
State or Country of Licensure / License #		**Fax**

Provider Office Stamp